## BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGYAND AUDIOLOGY 3700 N CLASSEN BLVD, STE 248 OKLAHOMA CITY, OK 73118

## REPORT OF CLINICAL FELLOWSHIP

NAME:			CF#:	
FIRST	MIDDLE	LAST		
HOME ADDRESS: _				
	STREET	CITY	STATE	ZIP
PHONE#:				
COMPANY NAME <u>D</u>	URING CF:			
WORK:				
STRE			STATE	ZIP
WORK#:				
NAME OF SUPERVI	SOR:		LICENSE #:	
COMPANY NAME <u>A</u>	FTER CF:			
S	STREET	CITY	STATE	ZIP
WORK#:		WK EMAIL:		
REQUIRMENTS	OF CLINICAL FE	LLOWSHIP:		
1. START DATE OF	CF:	COMPLETION	DATE OF CF:	
	EKS OF SUPERVISED weeks or more & PART		INIMUM 36 WEEKS) pre)	
<b>3. HOURS WORKE</b> (FULL TIME = 30+	PER WEEK:	15+ hours)		
(Supervisory monit	toring activities can inc	clude correspondence,	G: (MINIMU , videotape, audiotape, res, consultation with client	view of clinical

Please fill out the graph below to sho	ow your On-site observations	
* 1 hour =1 on-site observation		1 ords 1 ord GU 1 IF U
* At least 6 on-site observations must ha * A MAXIMUM of six (6) on-site obser	we been accrued during each 12-week (e	ach 3 <sup>rd</sup> ) period of the Clinical Fellowship
* On-site observation should include obs		
	nent (E), Habilitation (H), and Rehabi	litation (R)
First 12 weeks	Second 12 weeks	Third 12 weeks
Date/Type/ # of Hours	Date/Type/ # of Hours	Date/Type/ # of Hours
, p	, p =	
() I recommend	for S	I D licensure
( ) I do not recommend	for S	LF IICCIISUIC.
( ) I do not recommend	101 S	SLP licensure.
Reasons and Recommendations:		
HEDERY CERTIES THAT THE A	BOVE INFORMATION IS CORREC	т
THEREBY CERTIFY THAT THE A	BOVE INFORMATION IS CORREC	1.
Applicant's Signature:	Date: _	
I HEREBY CERTIFY THAT THE A	BOVE INFORMATION IS CORREC	Т.
	Date: _	
ouper abor a prementer	Datt	

5. NUMBER OF ON-SITE OBSERVATIONS OF DIRECT CLIENT CONTACT OF CF: \_\_\_\_\_ (MINIMUM 18)